seventeen years, of good physique, who had suffered since her thirteenth year from ptosis of the left upper eyelid, which set in every month, lasted three days, and was accompanied at its commencement by headache and vomiting. Menstruation began at the age of fifteen years, when it was observed that this coincided with the monthly ptosis of the left eye. The author had the opportunity of seeing the patient at the onset of one of her periods, and then made out total palsy of the muscles of the left eye; the second day of the menstrual period witnessed a recurrence of the paralysis of the left eyelid, of the headache, and vomiting. With the cessation of the menses on the third day, a gradual restoration of the movements of the eye took place, the pupils remaining dilated a little while longer.—*Med. Times & Gaz.*, No. 1719.

ICHTHYOSIS IN TABES.—In the *Progrès méd.* (No. 20) MM. Ballet and Dutil gave a short description of an ichthyotic condition of the skin which they have had occasion to observe in tabes, and which they regard as an essential part of the disease, and not as a mere coincidence. Compared with this, the lesions hitherto described,—*e. g.*, herpetic eruptions, ecchymoses, perforating ulcer of the foot, etc.—are to be regarded as mere transitory occurrences. The ichthyosis is slowly developed, probably progressive, and seems to be analogous to the now well-known osseous lesions. The lesion, when present, is always found in those situations in which there has been previously some marked disturbance of sensation, either anæsthesia or hyperæsthesia, or lightning pains. The limbs, and particularly the arms, would seem to be the parts most frequently affected. The falling off, or alteration of the nails, which have already been described, would seem to be merely an example of the same lesion. Disorders of nutrition, such as the one under consideration, accord very well with the idea of a peripheral lesion, which Pierret was the first to recognize. —*Med. Times & Gaz.*, No. 1723.

EYE-SYMPTOMS IN DISEASES OF THE CORD.—Dr. R. W. Gowers, in a paper read before the Ophthalmological Society, London (*British Medical Journal*, No. 1720.), confined his remarks to optic nerve atrophy and internal ocular paralysis. "Two general facts," he said, "respecting these symptoms deserve attention. The first is that we must regard them as associations and not effects of the spinal lesion. The evidence of this is: 1. That disease of any nature may exist in any part of the spinal cord without the occurrence of ocular symptoms, if we except the very rare paralysis of the dilators of the pupil in disease of the sympathetic tract in the cervical region. 2. The ocular symptoms, which may be absent when the cord disease is advanced, may exist in extreme degree when each disease is in a very early stage. 3. With the single exception of the sympathetic symptoms just mentioned, we know of no anatomical connection or functional mechanism by which the spinal-cord disease can produce the ocular symptoms. The second general fact is that these associated ocular symptoms are always the result of degenerative processes, and their presence shows that the cord disease is essentially degenerative in its nature." In answer to the question, in what proportion of cases of tabes does optic-nerve atrophy occur? he states that his own statistics yield about 20 per cent. of atrophy, which number he thinks has been increased by accidental circumstances, for which reason he estimates 15 per cent. as not far from the truth. The author refers the four muscular actions of the internal muscles of the eye (iris and ciliary muscle), namely: contraction of the ciliary muscle on accommodation, contraction of the sphincter iridis occurring with accommodation, contraction of the sphincter iridis on stimulation of the optic nerve, and contraction of the dilator fibres of the iris on stimulation of the skin. They depend on at least three centres, capable of separate action and liable to separate disease, all of which, probably, lie in a tract beneath the aqueduct of Sylvius, below the front part of the corpora quadrigemina. The most frequent disturbance is loss of reflex action to light, while the pupil contracts on an effort at accommodation (reflex-iridoplegia—Argyle-Robertson phenomenon), often associated, as first pointed out by Erb, with a loss of the dilatation on stimulation of the skin. Next in frequency, but much less common, is paralysis of all the muscles within the eye, both cycloplegia and iridoplegia, the "ophthalmoplegia interna" of Hutchinson. The rarest of all is loss of accommodation, cycloplegia, without loss of reflex action. In 72 cases of primary degenerative ataxy, the author found the internal muscles of the eye were normal in only 6; some defect existed in 66, or 92 per cent.; loss of reflex action to light was the only condition in 48, to which may be added 6 others with very slight action to light, and in 1 case the loss existed in one eye only. Thus, there was a total loss of the light reflex in about two thirds, and either total or partial loss in about three quarters of the whole number of cases. In the remaining 11 (15 per cent. of the whole) the pupil did not contract on an effort at accommodation, and in most of them it was clear that accommodation was also lost. In 6 there was total loss of accommodation and the light reflex, ophthalmoplegia interna. In 2 cases accommodation was lost in one eye and action to light in both. In 10 cases accommodation was lost in both eyes, and light reflex in one only. In 2 cases accommodation was lost, but the action to light was perfect. Of the 72 cases, 25 were in the first stage, 29 in the second, and 18 in the third. The percentage of cases with intra-ocular palsies was, in the first stage 84, in the second 93, and in the third 100. Thus in no case in the third stage were they absent. These facts show that in the majority of cases (four fifths) these ocular complications occur early, but also that cases which escape in the early stage usually suffer during the subsequent course of the disease. When the light-reflex is good the pupils are often but not invariably small. In two thirds of the cases they were below 2½ mm. in diameter. In the remainder they were 3 mm. to 3½ mm., and occasionally 4 mm. to 5 mm. Inequality in size is common in both conditions, also a slight irregularity in shape.

W. R. Birdsall, M.D.

c.—MENTAL PATHOLOGY.

Psychoses in Childhood.—Cohn (*Arch. für Kinderheilkunde*, Band iv) says that insanity in childhood, which may make its appearance at any time from birth on, is liable at first to be manifested in motor symptoms. Insanity in a child in whom the sensory-intellectual sphere is not yet developed, shows itself in a furor or frenzy analogous to that of the lower animals. In children in whom the sensory-intellectual sphere is developed, hallucinations present themselves, and later, delusions. The imagination is, however, strongly developed in children in this relation, and upon the question whether the active reproduction of the memory is recognized as such, turns the question of insanity. Under six years, psychoses are exceptional. Hereditary defect plays a strong part in the production of these psychoses, as also the period of puberty. The psychoses are divisible into those developing from the neuroses (chorea, epilepsy, hysteria, etc.), and those not related to these (hallucinatory confusion, hypochondriacal psychoses, melancholia, mania, monomania, and moral insanity). These researches confirm those of Scherpf (Band xvi) and previous authors.

Prolonged Baths in Mania.—J. Millet (*L' Encéphale*, No. 3, 1882) says that prolonged baths of a temperature of 77°–93° F., are very efficacious in combating maniacal paroxysms. Their constant effect is to moderate violence, lower temperature, and diminish pulse frequency. These results are more decided and persistent in proportion as the baths are given at lower temperature and for a longer period. The more violent the paroxysms, the colder and more prolonged the bath should be. Feeble constitution, emaciation, malnutrition, and fever, are indications for higher temperature and less duration of the bath. Baths of two to five hours, and of 77° to 82° F., should be administered to violent patients. If the bath be more prolonged, the temperature should be from 82° to 88°, especially if agitation be not excessive. Baths of 88° to 93° should be reserved for moderately excited cases who are emaciated, puny, or enfeebled by fever or malnutrition. While bathing, the head should be covered by cold compresses, frequently renewed, or else a current of cold water should be kept